

situation as constituting a substantial failure and would not invalidate the election under this section.

(j) *Election invalidated.* If CMS finds cause to invalidate an election under this section, the following rules apply:

(1) CMS notifies the plan sponsor (and the plan administrator if other than the plan sponsor and the administrator's address is known to CMS) in writing that CMS has made a preliminary determination that an election is invalid, and states the basis for that determination.

(2) CMS's notice informs the plan sponsor that it has 45 days after the date of CMS's notice to explain in writing why it believes its election is valid. The plan sponsor should provide applicable statutory and regulatory citations to support its position.

(3) CMS verifies that the plan sponsor's response is timely filed as provided under paragraph (d)(3) of this section. CMS will not consider a response that is not timely filed.

(4) If CMS's preliminary determination that an election is invalid remains unchanged after CMS considers the plan sponsor's timely response (or in the event that the plan sponsor fails to respond timely), CMS provides written notice to the plan sponsor (and the plan administrator if other than the plan sponsor and the administrator's address is known to CMS) of CMS's final determination that the election is invalid. Also, CMS informs the plan sponsor that, within 45 days of the date of the notice of final determination, the plan, subject to paragraph (i)(1)(iii) of this section, must comply with all requirements of this part for the specified period for which CMS has determined the election to be invalid.

(k) *Enforcement.* To the extent that an election under this section has not been filed or a non-Federal governmental plan otherwise is subject to one or more requirements of this part, CMS enforces those requirements under part 150 of this subchapter. This may include imposing a civil money penalty against the plan or the plan sponsor, as determined under § 150.305.

(l) *Construction.* Nothing in this section should be construed to prevent a State from taking the following actions:

(1) Establishing, and enforcing compliance with, the requirements of State law (as defined in § 146.143(d)(1)), including requirements that parallel provisions of title XXVII of the PHS Act, that apply to non-Federal governmental plans or sponsors.

(2) Prohibiting a sponsor of a non-Federal governmental plan within the State from making an election under this section.

[67 FR 48811, July 26, 2002]

PART 147 [RESERVED]

PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

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AUTHORITY: Secs. 2741 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg-41 through 300gg-63, 300gg-91, and 300gg-92).

SOURCE: 62 FR 16995, Apr. 8, 1997, unless otherwise noted.

Subpart A—General Provisions

§ 148.101 Basis and purpose.

This part implements sections 2741 through 2763 and 2791 and 2792 of the PHS Act. Its purpose is to improve access to individual health insurance coverage for certain eligible individuals who previously had group coverage, and to guarantee the renewability of all coverage in the individual market. It also provides certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth.

[63 FR 57561, Oct. 27, 1998]

§ 148.102 Scope, applicability, and effective dates.

(a) *Scope and applicability.* (1) Individual health insurance coverage includes all health insurance coverage (as defined in § 144.103) that is neither health insurance coverage sold in connection with an employment-related group health plan, nor short-term, limited-duration coverage as defined in § 144.103 of this subchapter. In some cases, coverage that may be considered group coverage under State law (such as coverage sold through certain associations) is considered individual coverage.

(2) The requirements of this part that pertain to guaranteed availability of individual health insurance coverage for certain eligible individuals apply to all issuers of individual health insurance coverage in a State, unless the State implements an acceptable alternative mechanism as described in § 148.128. The requirements that pertain to guaranteed renewability for all individuals, and to protections for mothers and newborns with respect to hospital stays in connection with childbirth, apply to all issuers of individual health insurance coverage in the State, re-

gardless of whether a State implements an alternative mechanism.

(b) *Effective date.* Except as provided in §§ 148.124 (certificate of coverage), 148.128 (alternative State mechanisms), and 148.170 (standards relating to benefits for mothers and newborns), the requirements of this part apply to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs.

[62 FR 16995, Apr. 8, 1997; 62 FR 31695, June 10, 1997, as amended at 63 FR 57562, Oct. 27, 1998]

§ 148.103 Definitions.

Unless otherwise provided, the following definition applies:

Eligible individual means an individual who meets the following conditions:

(1) The individual has at least 18 months of creditable coverage (as determined under § 146.113 of this subchapter) as of the date on which the individual seeks coverage under this part.

(2) The individual's most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any of these plans).

(3) The individual is not eligible for coverage under any of the following:

- (i) A group health plan.
- (ii) Part A or Part B of Title XVIII (Medicare) of the Social Security Act.
- (iii) A State plan under Title XIX (Medicaid) of the Social Security Act (or any successor program).

(4) The individual does not have other health insurance coverage.

(5) The individual's most recent coverage was not terminated because of nonpayment of premiums or fraud. (For more information about nonpayment of premiums or fraud, see § 146.152(b)(1) and (b)(2) of this subchapter.)

(6) If the individual has been offered the option of continuing coverage under a COBRA continuation provision or a similar State program, the individual has both elected and exhausted the continuation coverage.

Subpart B—Requirements Relating to Access and Renewability of Coverage

§ 148.120 Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

(a) *General rule.* Except as provided for in paragraph (c) of this section, an issuer that furnishes health insurance coverage in the individual market must meet the following requirements with respect to any eligible individual who requests coverage:

(1) May not decline to offer coverage or deny enrollment under any policy forms that it actively markets in the individual market, except as permitted in paragraph (c) of this section concerning alternative coverage when no State mechanism exists. An issuer is deemed to meet this requirement if, upon the request of an eligible individual, it acts promptly to do the following:

(i) Provide information about all available coverage options.

(ii) Enroll the individual in any coverage option the individual selects.

(2) May not impose any preexisting condition exclusion on the individual.

(b) *Exception.* The requirements of paragraph (a) of this section do not apply to health insurance coverage offered in the individual market in a State that chooses to implement an acceptable alternative mechanism described in § 148.128.

(c) *Alternative coverage permitted where no State mechanism exists—*(1) *General rule.* If the State does not implement an acceptable alternative mechanism under § 148.128, an issuer may elect to limit the coverage required under paragraph (a) of this section if it offers eligible individuals at least two policy forms that meet the following requirements:

(i) Each policy form must be designed for, made generally available to, and actively marketed to, and enroll, both eligible and other individuals.

(ii) The policy forms must be either the issuer's two most popular policy forms (as described in paragraph (c)(2) of this section) or representative samples of individual health insurance offered by the issuer in the State (as de-

scribed in paragraph (c)(3) of this section).

(2) *Most popular policies.* The *two most popular policy forms* means the policy forms with the largest, and the second largest, premium volume for the last reporting year, for policies offered in that State. In the absence of applicable State standards, *premium volume* means earned premiums for the last reporting year. In the absence of applicable State standards, the last reporting year is the period from October 1 through September 30 of the preceding year. Blocks of business closed under applicable State law are not included in calculating premium volume.

(3) *Representative policy forms—*(i) *Definition of weighted average.* Weighted average means the average actuarial value of the benefits provided by all the health insurance coverage issued by one of the following:

(A) An issuer in the individual market in a State during the previous calendar year, weighted by enrollment for each policy form, but not including coverage issued to eligible individuals.

(B) All issuers in the individual market in a State if the data are available for the previous calendar year, weighted by enrollment for each policy form.

(ii) *Requirements.* The two representative policy forms must meet the following requirements:

(A) Include a lower-level coverage policy form under which the actuarial value of benefits under the coverage is at least 85 percent but not greater than 100 percent of the weighted average.

(B) Include a higher-level coverage policy form under which the actuarial value of the benefits under the coverage is at least 15 percent greater than the actuarial value of the lower-level coverage policy form offered by an issuer in that State and at least 100 percent, but not greater than 120 percent, of the weighted average.

(C) Include benefits substantially similar to other individual health insurance coverage offered by the issuer in the State.

(D) Provide for risk adjustment, risk spreading, or a risk spreading mechanism, or otherwise provide some financial subsidization for eligible individuals.

(E) Meet all applicable State requirements.

(iii) *Actuarial value of benefits.* The actuarial value of benefits provided under individual health insurance coverage must be calculated based on a standardized population, and a set of standardized utilization and cost factors under applicable State law.

(4) *Election.* All issuer elections must be applied uniformly to all eligible individuals in the State and must be effective for all policies offered during a period of at least 2 years.

(5) *Documentation.* The issuer must document the actuarial calculations it makes as follows:

(i) *Enforcement by State.* In a State that elects to enforce the provisions of this section in lieu of an alternative mechanism under §148.128, the issuer must provide the appropriate State authorities with the documentation required by the State.

(ii) *Enforcement by CMS.* If CMS acts to enforce the provisions of this section under §148.200, the issuer must provide to CMS, within the following time frames, any documentation CMS requests:

(A) For policy forms already being marketed as of July 1, 1997—no later than September 1, 1997.

(B) For other policy forms—90 days before the beginning of the calendar year in which the issuer wants to market the policy form.

(d) *Special rules for network plans.* (1) An issuer that offers coverage in the individual market through a network plan may take the following actions:

(i) Specify that an eligible individual may only enroll if he or she lives, resides, or works within the service area for the network plan.

(ii) Deny coverage to an eligible individual if the issuer has demonstrated the following to the applicable State authority (if required by the State):

(A) It does not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to provide services to current group contract holders and enrollees, and to current individual enrollees.

(B) It uniformly denies coverage to individuals without regard to any health status-related factor, and with-

out regard to whether the individuals are eligible individuals.

(iii) Not offer any coverage in the individual market, within the service area identified for purposes of paragraph (d)(1)(ii) of this section, for a period of 180 days after the coverage is denied.

(2) In those States in which CMS is enforcing the individual market provisions of this part in accordance with §148.200, the issuer must make the demonstration described in paragraph (d)(1)(ii) of this section to CMS rather than to the State, and the issuer may not deny coverage to any eligible individual until 30 days after CMS receives and approves the information.

(e) *Application of financial capacity limits.* (1) An issuer may deny coverage to an eligible individual if the issuer has demonstrated the following to the applicable State authority (if required by the State):

(i) It does not have the financial reserves necessary to underwrite additional coverage.

(ii) It uniformly denies coverage to all individuals in the individual market, consistent with applicable State law, without regard to any health status-related factor of the individuals, and without regard to whether the individuals are eligible individuals.

(2) In those States in which CMS is enforcing the individual market provisions of this part in accordance with §148.200, the issuer must make the demonstration described in paragraph (e)(1) of this section to CMS rather than to the State, and the issuer may not deny coverage to any eligible individual until 30 days after CMS receives and approves the information.

(3) An issuer that denies coverage in any service area according to paragraph (e)(1) of this section is prohibited from offering that coverage in the individual market for a period of 180 days after the later of the date—

(i) The coverage is denied; or

(ii) The issuer demonstrates to the applicable State authority (if required under applicable State law) that the issuer has sufficient financial reserves to underwrite additional coverage.

(4) A State may apply the 180-day suspension described in paragraph

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(e)(3) of this section on a service-area-specific basis.

(f) *Rules for dependents*—(1) *General rule.* If an eligible individual elects to enroll in individual health insurance coverage that provides coverage for dependents, the issuer may apply a preexisting condition exclusion on any dependent who is not an eligible individual.

(2) *Exception for certain children.* A child is deemed to be an eligible individual if the following conditions are met:

(i) The child was covered under any creditable coverage within 30 days of birth, adoption, or placement for adoption (or longer if the State provides for a longer special enrollment period than required under § 146.117(a)(6) of this subchapter).

(ii) The child has not had a significant break in coverage.

(3) *Examples.* The following examples illustrate the requirements of this paragraph (f) for certain children:

Example 1: Individual *A* had self-only coverage under his employer's group health plan for five years. *A* has two children, ages 11 and 15, but never enrolled in family coverage. *A* leaves his job to become self-employed, and qualifies as an eligible individual because he is not entitled to any continuation coverage, Medicare or Medicaid, and has no other health insurance coverage. He applies to Issuer *R* for coverage in the individual market under a policy with family coverage that *R* makes available to eligible individuals. *R* must sell *A* the policy, but he may refuse coverage to *A*'s children, or may apply a preexisting condition exclusion to them if allowed under applicable State law, because they did not have prior creditable coverage, and therefore do not qualify as eligible individuals.

Example 2: Individual *B* was also covered under a group health plan for 5 years before losing his job. He originally had coverage only for himself and his wife, but 3 months before his employment ended, his wife had a baby. *B* took advantage of the special enrollment period that applied, changed to family coverage, and enrolled the baby in the group health plan within 20 days. Immediately after losing his job, *B* applied to Issuer *R* for family coverage. *B* and his wife qualify as eligible individuals, and the baby is deemed to be an eligible individual even though she has less than 3 months of creditable coverage. Therefore *R* must make the policy available to all three members of the family, and cannot impose any preexisting condition exclusions.

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(g) *Clarification of applicability.* (1) An issuer in the individual market is not required to offer a family coverage option with any policy form.

(2) An issuer offering health insurance coverage only in connection with group health plans, or only through one or more bona fide associations, or both, is not required to offer that type of coverage in the individual market.

(3) An issuer offering health insurance coverage in connection with a group health plan is not deemed to be a health insurance issuer offering individual health insurance coverage solely because the issuer offers a conversion policy.

(4) This section does not restrict the amount of the premium rates that an issuer may charge an individual under State law for health insurance coverage provided in the individual market.

(5) This section does not prevent an issuer offering health insurance coverage in the individual market from establishing premium discounts or rebates, or modifying otherwise applicable copayments or deductibles, in return for adherence to programs of health promotion and disease prevention.

(6) This section does not require issuers to reopen blocks of business closed under applicable State law.

(Approved by the Office of Management and Budget under control number 0938–0703)

[62 FR 16996, Apr. 8, 1997; 62 FR 31696, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

§ 148.122 Guaranteed renewability of individual health insurance coverage.

(a) *Applicability.* This section applies to all health insurance coverage in the individual market.

(b) *General rules.* (1) Except as provided in paragraph (c) of this section, an issuer must renew or continue in force the coverage at the option of the individual.

(2) Medicare eligibility or entitlement is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market.

(c) *Exceptions to renewing coverage.* An issuer may nonrenew or discontinue

health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) *Nonpayment of premiums.* The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.

(2) *Fraud.* The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) *Termination of plan.* The issuer is ceasing to offer coverage in the individual market in accordance with paragraphs (d) and (e) of this section and applicable State law.

(4) *Movement outside the service area.* For network plans, the individual no longer resides, lives, or works in the service area of the issuer, or area for which the issuer is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(5) *Association membership ceases.* For coverage made available in the individual market only through one or more bona fide associations, the individual's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(d) *Discontinuing a particular type of coverage.* An issuer may discontinue offering a particular type of health insurance coverage offered in the individual market only if it meets the following requirements:

(1) Provides notice in writing to each individual provided coverage of that type of health insurance at least 90 days before the date the coverage will be discontinued.

(2) Offers to each covered individual, on a guaranteed issue basis, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in that market.

(3) Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

(e) *Discontinuing all coverage.* An issuer may discontinue offering all health insurance coverage in the individual market in a State only if it meets the following requirements.

(1) Provides notice in writing to the applicable State authority and to each individual of the discontinuation at least 180 days before the date the coverage will expire.

(2) Discontinues and does not renew all health insurance policies it issues or delivers for issuance in the State in the individual market.

(3) Acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

(f) *Prohibition on market reentry.* An issuer who elects to discontinue offering all health insurance coverage under paragraph (e) of this section may not issue coverage in the market and State involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

(g) *Exception for uniform modification of coverage.* An issuer may, only at the time of coverage renewal, modify the health insurance coverage for a policy form offered in the individual market if the modification is consistent with State law and is effective uniformly for all individuals with that policy form.

(h) *Application to coverage offered only through associations.* In the case of health insurance coverage that is made available by a health insurance issuer in the individual market only through one or more associations, any reference in this section to an "individual" is deemed to include a reference to the association of which the individual is a member.

(Approved by the Office of Management and Budget under control number 0938-0703)

[62 FR 16998, Apr. 8, 1997; 62 FR 31696, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

§ 148.124 Certification and disclosure of coverage.

(a) *Applicability*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, this section applies to all issuers of health insurance coverage.

(2) *Exception.* The provisions of this section do not apply to issuers of the following types of coverage:

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(i) Health insurance coverage furnished in connection with a group health plan defined in §144.103 of this subchapter. (These issuers are required under §146.115 of this subchapter to provide a certificate of coverage.)

(ii) Excepted benefits described in §148.220.

(iii) Short-term, limited duration coverage defined in §144.103 of this subchapter.

(b) *General rules*—(1) *Individuals for whom a certificate must be provided; timing of issuance.* A certificate must be provided, without charge, for individuals and dependents who are or were covered under an individual health insurance policy as follows:

(i) *Issuance of automatic certificates.* An automatic certificate must be provided within a reasonable time period consistent with State law after the individual ceases to be covered under the policy.

(ii) *Any individual upon request.* Requests for certificates may be made by, or on behalf of, an individual within 24 months after coverage ends. For example, an entity that provides coverage to an individual in the future may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from the issuer of the individual's prior coverage. After the request is received, an issuer must provide the certificate by the earliest date the issuer, acting in a reasonable and prompt fashion, can provide the certificate. A certificate must be provided under this paragraph even if the individual has previously received a certificate under this paragraph (b)(1)(ii) or an automatic certificate under paragraph (a)(1)(i) of this section.

(2) *Form and content of certificate*—(i) *Written certificate*—(A) *General rule.* Except as provided in paragraph (b)(2)(i)(B) of this section, the issuer must provide the certificate in writing (including any form approved by CMS).

(B) *Other permissible forms.* No written certificate must be provided if all of the following occur:

(1) An individual is entitled to receive a certificate.

(2) The individual requests that the certificate be sent to another plan or issuer instead of to the individual.

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(3) The plan or issuer that would otherwise receive the certificate agrees to accept the information in paragraph (a)(3) of this section through means other than a written certificate (for example, by telephone).

(4) The receiving plan or issuer receives the information from the sending issuer in the prescribed form within the time periods required under paragraph (b)(1) of this section.

(ii) *Required information.* The certificate must include the following:

(A) The date the certificate is issued.

(B) The name of the individual or dependent for whom the certificate applies, and any other information necessary for the issuer providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the policy and the name of the policyholder if the certificate is for (or includes) a dependent.

(C) The name, address, and telephone number of the issuer required to provide the certificate.

(D) The telephone number to call for further information regarding the certificate (if different from paragraph (b)(2)(ii)(C) of this section).

(E) Either one of the following:

(1) A statement that the individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage as defined in §146.113(b)(2)(iii) of this subchapter.

(2) Both the date the individual first sought coverage, as evidenced by a substantially complete application, and the date creditable coverage began.

(F) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.

(iii) *Periods of coverage under a certificate.* If an automatic certificate is provided under paragraph (b)(1)(i) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate under paragraph (b)(1)(ii) of this section, a certificate must be provided for each period of continuous coverage ending

within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each period of continuous coverage.

(iv) *Single certificate permitted for families.* An issuer may provide a single certificate for both an individual and the individual's dependents if it provides all the required information for each individual and dependent, and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (b)(2)(ii) of this section are satisfied if the issuer provides a certificate in accordance with a model certificate as provided by CMS.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in §148.220. If excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (c) of this section.

(3) *Procedures*—(i) *Method of delivery.* The certificate is required to be provided, without charge, to each individual described in paragraph (b)(1) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the individual and the individual's spouse at the individual's last known address, the requirements of this paragraph (b)(3) are satisfied with respect to all individuals and dependents residing at that address. If a dependent's last known address is different than the individual's last known address, a separate certificate must be provided to the dependent at the dependent's last known address. If separate certificates are provided by mail to individuals and dependents who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* An issuer must establish a procedure for individuals and dependents to request and receive certificates under paragraph (b)(1)(ii) of this section.

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (b)(1)(i) of this section, and the individual or dependent entitled to receive the certificate designates another individual or entity to receive the certificate, the issuer responsible for providing the certificate may provide the certificate to the designated party. If a certificate must be provided upon request under paragraph (b)(1)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the issuer responsible for providing the certificates must provide the certificate to the designated party.

(4) *Special rules concerning dependent coverage*—(i) *Reasonable efforts.* An issuer must use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. If an automatic certificate must be furnished with respect to a dependent under paragraph (b)(1)(i) of this section, no individual certificate must be furnished until the issuer knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the policy.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by an issuer does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (d)(3) of this section for demonstrating dependent status. An individual may, if necessary, use these procedures to demonstrate that a child was enrolled within 30 days of birth, adoption, or placement for adoption, in which case the child would not be subject to a preexisting condition exclusion under §148.120(f)(2).

(iii) *Transition rule for dependent coverage through June 30, 1998*—(A) *General rule.* An issuer that cannot provide the names of dependents (or related coverage information) for purposes of providing a certificate of coverage for a dependent may satisfy the requirements of paragraph (b)(2)(ii)(C) of this section by providing the name of the policyholder and specifying that the type of coverage described in the certificate is for dependent coverage (for

example, family coverage or individual-plus-spouse coverage).

(B) *Certificates provided on request.* For purposes of certificates provided on the request of, or on behalf of, an individual under paragraph (b)(1)(ii) of this section, an issuer must make reasonable efforts to obtain and provide the names of any dependent covered by the certificate if the information is requested. If a certificate does not include the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (d)(3) of this section for submitting documentation to establish that the creditable coverage in the certificate applies to the dependent.

(C) *Demonstrating a dependent's creditable coverage.* See paragraph (d)(3) of this section for special rules to demonstrate dependent status.

(D) *Duration.* The transitional rules of this paragraph (b)(4)(iii) are effective for certifications provided with respect to an event occurring before July 1, 1998.

(5) *Optional notice.* This paragraph applies to events described in paragraph (b)(1)(i) of this section, that occur after September 30, 1996, but before June 30, 1997. An issuer offering individual health insurance coverage is deemed to satisfy paragraphs (b)(1) and (b)(2) of this section if a notice is provided in accordance with the provisions of § 146.125(e)(3)(ii) through (e)(3)(iv) of this subchapter.

(c) *Disclosure of coverage to a plan, or issuer, electing the alternative method of creating coverage—(1) General rule.* If an individual enrolls in a group health plan and the plan or issuer uses the alternative method of determining creditable coverage described in § 146.113(c) of this subchapter, the individual provides a certificate of coverage under paragraph (b) of this section or demonstrates creditable coverage under paragraph (d) of this section, and the plan or coverage in which the individual enrolls requests from the prior entity, the prior entity must disclose promptly to the requesting plan or issuer ("requesting entity") the information set forth in paragraph (c)(2) of this section.

(2) *Information to be disclosed.* The prior entity must identify to the requesting entity the categories of benefits under which the individual was covered and with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs to determine the individual's creditable coverage with respect to any of those categories. The prior entity must promptly disclose to the requesting entity the creditable coverage information that was requested.

(3) *Charge for providing information.* The prior entity furnishing the information under paragraph (c)(2) of this section may charge the requesting entity for the reasonable cost of disclosing the information.

(d) *Ability of an individual to demonstrate creditable coverage and waiting period information—(1) General rule.* Individuals may establish creditable coverage through means other than certificates. If the accuracy of a certificate is contested or a certificate is unavailable when needed by the individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make a demonstration if one of the following occurs:

(i) An entity has failed to provide a certificate within the required time period.

(ii) The individual has creditable coverage but an entity may not be required to provide a certificate of the coverage.

(iii) The coverage is for a period before July 1, 1996.

(iv) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan.

(v) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(2) *Evidence of creditable coverage—(i) Consideration of evidence.* An issuer must take into account all information that it obtains or that is presented on

behalf of an individual to make a determination, based on the relevant facts and circumstances, whether or not an individual has 18 months of creditable coverage. An issuer must treat the individual as having furnished a certificate if the individual attests to the period of creditable coverage, the individual presents relevant corroborating evidence of some creditable coverage during the period, and the individual cooperates with the issuer's efforts to verify the individual's coverage. For this purpose, cooperation includes providing (upon the issuer's request) a written authorization for the issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While an issuer may refuse to credit coverage if the individual fails to cooperate with the issuer's efforts to verify coverage, the issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that may establish creditable coverage (and waiting periods or affiliation periods) in the absence of a certificate include explanations of benefit claims (EOB) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting period or affiliation period information) may be established through means other than documentation, such as by a telephone call from the issuer to a third party verifying creditable coverage.

(3) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the issuer must treat the individual as having furnished a certificate showing the dependent status if the individual attests

to the dependency and the period of the status and the individual cooperates with the issuer's efforts to verify the dependent status.

(Approved by the Office of Management and Budget under control number 0938-0703)

[62 FR 16998, Apr. 8, 1997; 62 FR 31696, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

§ 148.126 Determination of an eligible individual.

(a) *General rule.* Each issuer offering health insurance coverage in the individual market is responsible for determining whether an applicant for coverage is an eligible individual as defined in § 148.103.

(b) *Specific requirements.* (1) The issuer must exercise reasonable diligence in making this determination.

(2) The issuer must promptly determine whether an applicant is an eligible individual.

(3) If an issuer determines that an individual is an eligible individual, the issuer must promptly issue a policy to that individual.

(c) *Insufficient information.*—(1) *General rule.* If the information presented in or with an application is substantially insufficient for the issuer to make the determination described in paragraph (b)(2) of this section, the issuer may immediately request additional information from the individual, and must act promptly to make its determination after receipt of the requested information

(2) *Failure to provide a certification of creditable coverage.* If an entity fails to provide the certificate that is required under this part or part 146 of this subchapter to the applicant, the issuer is subject to the procedures set forth in § 148.124(d)(1) concerning an individual's right to demonstrate creditable coverage.

[62 FR 17000, Apr. 8, 1997]

EFFECTIVE DATE NOTE: At 62 FR 17000, Apr. 8, 1997, § 148.126 was added. This section contains information collection and record-keeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

§ 148.128 State flexibility in individual market reforms—alternative mechanisms.

(a) *Waiver of requirements.* The requirements of § 148.120, which set forth Federal requirements for guaranteed availability in the individual market, do not apply in a State that implements an acceptable alternative mechanism in accordance with the following criteria:

(1) The alternative mechanism meets the following conditions:

(i) Offers health insurance coverage to all eligible individuals.

(ii) Prohibits imposing preexisting condition exclusions and affiliation periods for coverage of an eligible individual.

(iii) Offers an eligible individual a choice of coverage that includes at least one policy form of coverage that is comparable to either one of the following:

(A) Comprehensive coverage offered in the individual market in the State.

(B) A standard option of coverage available under the group or individual health insurance laws of the State.

(2) The State is implementing one of the following provisions relating to risk:

(i) One of the following model acts, as adopted by the NAIC on June 3, 1996, but only if the model has been revised in State regulations to meet all of the requirements of this part and title 27 of the PHS Act.

(A) The Small Employer and Individual Health Insurance Availability Model Act to the extent it applies to individual health insurance coverage.

(B) The Individual Health Insurance Portability Model Act.

(ii) A qualified high risk pool, which, for purposes of this section, is a high risk pool that meets the following conditions:

(A) Provides to all eligible individuals health insurance coverage (or comparable coverage) that does not impose any preexisting condition exclusion or affiliation periods for coverage of an eligible individual.

(B) Provides for premium rates and covered benefits for the coverage consistent with standards included in the NAIC Model Health Plan for Uninsurable Individuals Act (as in effect as of

August 21, 1996), but only if the model has been revised in State regulations to meet all of the requirements of this part and title 27 of the PHS Act.

(iii) One of the following mechanisms:

(A) Any other mechanism that provides for risk adjustment, risk spreading, or a risk-spreading mechanism (among issuers or policies of an issuer) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating issuers.

(B) A mechanism that provides a choice for each eligible individual of all individual health insurance coverage otherwise available.

(b) *Permissible forms of mechanisms.* A private or public individual health insurance mechanism (such as a health insurance coverage pool or program, a mandatory group conversion policy, guaranteed issue of one or more plans of individual health insurance coverage, or open enrollment by one or more health insurance issuers), or combination of these mechanisms, that is designed to provide access to health benefits for individuals in the individual market in the State, in accordance with this section, may constitute an acceptable alternative mechanism.

(c) *Establishing an acceptable alternative mechanism—transition rules.* CMS presumes a State to be implementing an acceptable alternative mechanism as of July 1, 1997 if the following conditions are met:

(1) By not later than April 1, 1997, as evidenced by a postmark date, or other such date, the chief executive officer of the State takes the following actions:

(i) Notifies CMS that the State has enacted or intends to enact by not later than January 1, 1998 (unless it is a State described in paragraph (d) of this section), any legislation necessary to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of January 1, 1998.

(ii) Provides CMS with the information necessary to review the mechanism and its implementation (or proposed implementation).

(2) CMS has not made a determination, in accordance with the procedure in paragraph (e)(4) of this section, that

the State will not be implementing a mechanism reasonably designed to be an acceptable alternative mechanism as of January 1, 1998.

(d) *Delay permitted for certain States.* If a State notifies CMS that its legislature is not meeting in a regular session between August 21, 1996 and August 20, 1997, CMS continues to presume until July 1, 1998 that the State is implementing an acceptable alternative mechanism, if the chief executive officer of the State takes the following actions:

(1) Notifies CMS by April 1, 1997, that the State intends to submit an alternative mechanism and intends to enact any necessary legislation to provide for the implementation of an acceptable alternative mechanism as of July 1, 1998.

(2) Notifies CMS by April 1, 1998, that the State has enacted any necessary legislation to provide for the implementation of an acceptable alternative mechanism as of July 1, 1998.

(3) Provides CMS with the information necessary to review the mechanism and its implementation (or proposed implementation).

(e) *Submitting an alternative mechanism after April 1, 1997—(1) Notice with information.* A State that wishes to implement an acceptable alternative mechanism must take the following actions:

(i) Notify CMS that it has enacted legislation necessary to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism, and

(ii) Provide CMS with the information necessary for CMS to review the mechanism and its implementation (or proposed implementation).

(2) *An acceptable alternative mechanism.* If the State takes the actions described in paragraph (e)(1) of this section, the mechanism is considered to be an acceptable alternative mechanism unless CMS makes a preliminary determination (under paragraph (e)(4)(i) of this section), within the review period (defined in paragraph (e)(3) of this section), that the mechanism is not an acceptable alternative mechanism.

(3) *Review period—(i) General.* The review period begins on the date the State's notice and information are re-

ceived by CMS, and ends 90 days later, not counting any days during which the review period is suspended under paragraph (e)(3)(ii) of this section.

(ii) *Suspension of review period.* During any review period, if CMS notifies the State of the need for additional information or further discussion on its submission, CMS suspends the review period until the State provides the necessary information.

(4) *Determination by CMS—(i) Preliminary determination.* If CMS finds after reviewing the submitted information, and after consultation with the chief executive officer of the State and the chief insurance regulatory official of the State, that the mechanism is not an acceptable alternative mechanism, CMS takes the following actions:

(A) Notifies the State, in writing, of the preliminary determination.

(B) Informs the State that if it fails to implement an acceptable alternative mechanism, the Federal guaranteed availability provisions of §148.120 will take effect.

(C) Permits the State a reasonable opportunity to modify the mechanism (or to adopt another mechanism).

(ii) *Final determination.* If, after providing notice and a reasonable opportunity for the State to modify its mechanism, CMS makes a final determination that the design of the State's alternative mechanism is not acceptable or that the State is not substantially enforcing an acceptable alternative mechanism, CMS notifies the State in writing of the following:

(A) CMS's final determination.

(B) That the requirements of §148.120 concerning guaranteed availability apply to health insurance coverage offered in the individual market in the State as of a date specified in the notice from CMS.

(iii) *State request for early notice.* A State may request that CMS notify the State before the end of the review period if CMS is not making a preliminary determination.

(5) *Effective date.* If CMS does not make a preliminary determination within the review period, the acceptable alternative mechanism is effective 90 days after the end of the 90-day review period described in paragraph (e)(3)(i) of this section.

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(f) *Continued application.* A State alternative mechanism may continue to be presumed to be acceptable, if the State provides information to CMS that meets the following requirements:

(1) If the State makes a significant change to its alternative mechanism, it provides the information before making a change.

(2) Every 3 years from the later of implementing the alternative mechanism or implementing a significant change, it provides CMS with information.

(g) *Review criteria.* CMS reviews each State's submission to determine whether it addresses all of the following requirements:

(1) Is the mechanism reasonably designed to provide all eligible individuals with a choice of health insurance coverage?

(2) Does the choice offered to eligible individuals include at least one policy form that meets one of the following requirements?

(i) Is the policy form comparable to comprehensive health insurance coverage offered in the individual market in the State?

(ii) Is the policy form comparable to a standard option of coverage available under the group or individual health insurance laws of the State?

(3) Does the mechanism prohibit pre-existing condition exclusions for all eligible individuals?

(4) Is the State implementing one of the following:

(i) The NAIC Small Employer and Individual Health Insurance Availability Model Act (Availability Model), adopted on June 3, 1996, revised to reflect HIPAA requirements.

(ii) The Individual Health Insurance Portability Model Act (Portability Model), adopted on June 3, 1996, revised to reflect HIPAA requirements.

(iii) A qualified high-risk pool that provides eligible individuals health insurance or comparable coverage without a preexisting condition exclusion, and with premiums and benefits consistent with the NAIC Model Health Plan for Uninsurable Individuals Act (as in effect August 21, 1996), revised to reflect HIPAA requirements.

(iv) A mechanism that provides for risk spreading or provides eligible indi-

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viduals with a choice of all available individual health insurance coverage.

(5) Has the State enacted all legislation necessary for implementing the alternative mechanism?

(6) If the State has not enacted all legislation necessary for implementing the alternative mechanism, will the necessary legislation be enacted by January 1, 1998?

(h) *Limitation of CMS's authority.* CMS does not make a preliminary or final determination on any basis other than that a mechanism is not considered an acceptable alternative mechanism or is not being implemented.

(Approved by the Office of Management and Budget under control number 0938-0703)

[62 FR 16995, Apr. 8, 1997; 62 FR 17005, Apr. 8, 1997; 62 FR 31696, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

Subpart C—Requirements Related to Benefits

§ 148.170 Standards relating to benefits for mothers and newborns.

(a) *Hospital length of stay—(1) General rule.* Except as provided in paragraph (a)(5) of this section, an issuer offering health insurance coverage in the individual market that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than—

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) *When stay begins—(i) Delivery in a hospital.* If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) *Delivery outside a hospital.* If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

(3) *Examples.* The rules of paragraphs (a)(1) and (a)(2) of this section are illustrated by the following examples. In each example, the issuer provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

Example 1. (i) A pregnant woman covered under a policy issued in the individual market goes into labor and is admitted to the hospital at 10 p.m. on June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) In this *Example 1*, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.

Example 2. (i) A woman covered under a policy issued in the individual market gives birth at home by vaginal delivery. After the delivery, the woman begins bleeding excessively in connection with the childbirth and is admitted to the hospital for treatment of the excessive bleeding at 7 p.m. on October 1.

(ii) In this *Example 2*, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 7 p.m. on October 3.

Example 3. (i) A woman covered under a policy issued in the individual market gives birth by vaginal delivery at home. The child later develops pneumonia and is admitted to the hospital. The attending provider determines that the admission is not in connection with childbirth.

(ii) In this *Example 3*, the hospital length-of-stay requirements of this section do not apply to the child's admission to the hospital because the admission is not in connection with childbirth.

(4) *Authorization not required*—(i) *In general.* An issuer may not require that a physician or other health care provider obtain authorization from the issuer for prescribing the hospital length of stay required under paragraph (a)(1) of this section. (See also paragraphs (b)(2) and (c)(3) of this section for rules and examples regarding other authorization and certain notice requirements.)

(ii) *Example.* The rule of this paragraph (a)(4) is illustrated by the following example:

Example. (i) In the case of a delivery by cesarean section, an issuer subject to the requirements of this section automatically provides benefits for any hospital length of stay of up to 72 hours. For any longer stay, the issuer requires an attending provider to complete a certificate of medical necessity. The issuer then makes a determination, based on the certificate of medical necessity,

whether a longer stay is medically necessary.

(ii) In this *Example*, the requirement that an attending provider complete a certificate of medical necessity to obtain authorization for the period between 72 hours and 96 hours following a delivery by cesarean section is prohibited by this paragraph (a)(4).

(5) *Exceptions*—(i) *Discharge of mother.* If a decision to discharge a mother earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother, the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(ii) *Discharge of newborn.* If a decision to discharge a newborn child earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother (or the newborn's authorized representative), the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(iii) *Attending provider defined.* For purposes of this section, *attending provider* means an individual who is licensed under applicable State law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child.

(iv) *Example.* The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) A pregnant woman covered under a policy offered by an issuer subject to the requirements of this section goes into labor and is admitted to a hospital. She gives birth by cesarean section. On the third day after the delivery, the attending provider for the mother consults with the mother, and the attending provider for the newborn consults with the mother regarding the newborn. The attending providers authorize the early discharge of both the mother and the newborn. Both are discharged approximately 72 hours after the delivery. The issuer pays for the 72-hour hospital stays.

(ii) In this *Example*, the requirements of this paragraph (a) have been satisfied with respect to the mother and the newborn. If either is readmitted, the hospital stay for the readmission is not subject to this section.

(b) *Prohibitions*—(1) *With respect to mothers*—(i) *In general.* An issuer may not—

(A) Deny a mother or her newborn child eligibility or continued eligibility to enroll in or renew coverage solely to avoid the requirements of this section; or

(B) Provide payments (including payments-in-kind) or rebates to a mother to encourage her to accept less than the minimum protections available under this section.

(ii) *Examples.* The rules of this paragraph (b)(1) are illustrated by the following examples. In each example, the issuer is subject to the requirements of this section, as follows:

Example 1. (i) An issuer provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. If a mother and newborn covered under a policy issued in the individual market are discharged within 24 hours after the delivery, the issuer will waive the copayment and deductible.

(ii) In this *Example 1*, because waiver of the copayment and deductible is in the nature of a rebate that the mother would not receive if she and her newborn remained in the hospital, it is prohibited by this paragraph (b)(1). (In addition, the issuer violates paragraph (b)(2) of this section because, in effect, no copayment or deductible is required for the first portion of the stay and a double copayment and a deductible are required for the second portion of the stay.)

Example 2. (i) An issuer provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. In the event that a mother and her newborn are discharged earlier than 48 hours and the discharges occur after consultation with the mother in accordance with the requirements of paragraph (a)(5) of this section, the issuer provides for a follow-up visit by a nurse within 48 hours after the discharges to provide certain services that the mother and her newborn would otherwise receive in the hospital.

(ii) In this *Example 2*, because the follow-up visit does not provide any services beyond what the mother and her newborn would receive in the hospital, coverage for the follow-up visit is not prohibited by this paragraph (b)(1).

(2) *With respect to benefit restrictions—*

(i) *In general.* Subject to paragraph (c)(3) of this section, an issuer may not restrict the benefits for any portion of a hospital length of stay required under paragraph (a) of this section in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

(ii) *Example.* The rules of this paragraph (b)(2) are illustrated by the following example:

Example. (i) An issuer subject to the requirements of this section provides benefits for hospital lengths of stay in connection with childbirth. In the case of a delivery by cesarean section, the issuer automatically pays for the first 48 hours. With respect to each succeeding 24-hour period, the covered individual must call the issuer to obtain precertification from a utilization reviewer, who determines if an additional 24-hour period is medically necessary. If this approval is not obtained, the issuer will not provide benefits for any succeeding 24-hour period.

(ii) In this *Example*, the requirement to obtain precertification for the two 24-hour periods immediately following the initial 48-hour stay is prohibited by this paragraph (b)(2) because benefits for the latter part of the stay are restricted in a manner that is less favorable than benefits for a preceding portion of the stay. (However, this section does not prohibit an issuer from requiring precertification for any period after the first 96 hours.) In addition, if the issuer's utilization reviewer denied any mother or her newborn benefits within the 96-hour stay, the issuer would also violate paragraph (a) of this section.

(3) *With respect to attending providers.* An issuer may not directly or indirectly—

(i) Penalize (for example, take disciplinary action against or retaliate against), or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a covered individual in accordance with this section; or

(ii) Provide monetary or other incentives to an attending provider to induce the provider to furnish care to a covered individual in a manner inconsistent with this section, including providing any incentive that could induce an attending provider to discharge a mother or newborn earlier than 48 hours (or 96 hours) after delivery.

(c) *Construction.* With respect to this section, the following rules of construction apply:

(1) *Hospital stays not mandatory.* This section does not require a mother to—

(i) Give birth in a hospital; or

(ii) Stay in the hospital for a fixed period of time following the birth of her child.

(2) *Hospital stay benefits not mandated.* This section does not apply to any

issuer that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) *Cost-sharing rules*—(i) *In general.* This section does not prevent an issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn under the coverage, except that the coinsurance or other cost-sharing for any portion of the hospital length of stay required under paragraph (a) of this section may not be greater than that for any preceding portion of the stay.

(ii) *Examples.* The rules of this paragraph (c)(3) are illustrated by the following examples. In each example, the issuer is subject to the requirements of this section, as follows:

Example 1. (i) An issuer provides benefits for at least a 48-hour hospital length of stay in connection with vaginal deliveries. The issuer covers 80 percent of the cost of the stay for the first 24-hour period and 50 percent of the cost of the stay for the second 24-hour period. Thus, the coinsurance paid by the patient increases from 20 percent to 50 percent after 24 hours.

(ii) In this *Example 1*, the issuer violates the rules of this paragraph (c)(3) because coinsurance for the second 24-hour period of the 48-hour stay is greater than that for the preceding portion of the stay. (In addition, the issuer also violates the similar rule in paragraph (b)(2) of this section.)

Example 2. (i) An issuer generally covers 70 percent of the cost of a hospital length of stay in connection with childbirth. However, the issuer will cover 80 percent of the cost of the stay if the covered individual notifies the issuer of the pregnancy in advance of admission and uses whatever hospital the issuer may designate.

(ii) In this *Example 2*, the issuer does not violate the rules of this paragraph (c)(3) because the level of benefits provided (70 percent or 80 percent) is consistent throughout the 48-hour (or 96-hour) hospital length of stay required under paragraph (a) of this section. (In addition, the issuer does not violate the rules in paragraph (a)(4) or paragraph (b)(2) of this section.)

(4) *Compensation of attending provider.* This section does not prevent an issuer from negotiating with an attending provider the level and type of compensation for care furnished in accordance with this section (including paragraph (b) of this section).

(5) *Applicability.* This section applies to all health insurance coverage issued in the individual market, and is not limited in its application to coverage that is provided to eligible individuals as defined in section 2741(b) of the PHS Act.

(d) *Notice requirement.* Except as provided in paragraph (d)(4) of this section, an issuer offering health insurance in the individual market must meet the following requirements with respect to benefits for hospital lengths of stay in connection with childbirth:

(1) *Required statement.* The insurance contract must disclose information that notifies covered individuals of their rights under this section.

(2) *Disclosure notice.* To meet the disclosure requirement set forth in paragraph (d)(1) of this section, the following disclosure notice must be used:

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

(3) *Timing of disclosure.* The disclosure notice in paragraph (d)(2) of this section shall be furnished to the covered individuals in the form of a copy of the contract, or a rider (or equivalent amendment to the contract), not later than March 1, 1999.

(4) *Exception.* The requirements of this paragraph (d) do not apply with respect to coverage regulated under a

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State law described in paragraph (e) of this section.

(e) *Applicability in certain States—(1) Health insurance coverage.* The requirements of section 2751 of the PHS Act and this section do not apply with respect to health insurance coverage in the individual market if there is a State law regulating the coverage that meets any of the following criteria:

(i) The State law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section.

(ii) The State law requires the coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.

(iii) The State law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph (e)(1)(iii).

(2) *Relation to section 2762(a) of the PHS Act.* The preemption provisions contained in section 2762(a) of the PHS Act and § 148.210(b) do not supersede a State law described in paragraph (e)(1) of this section.

(f) *Effective date.* Section 2751 of the PHS Act applies to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1998. This section applies to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1999.

[63 FR 57562, Oct. 27, 1998]

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Subpart D—Enforcement; Penalties; Preemption

§ 148.210 Preemption.

(a) *Scope.* (1) This section describes the effect of sections 2741 through 2763 and 2791 of the PHS Act on a State's authority to regulate health insurance issuers in the individual market. This section makes clear that States remain subject to section 514 of ERISA, which generally preempts State law that relates to ERISA-covered plans.

(2) Sections 2741 through 2763 and 2791 of the PHS Act cannot be construed to affect or modify the provisions of section 514 of ERISA.

(b) *Regulation of insurance issuers.* The individual market rules of this part do not prevent a State law from establishing, implementing, or continuing in effect standards or requirements unless the standards or requirements prevent the application of a requirement of this part.

§ 148.220 Excepted benefits.

The requirements of this part do not apply to individual health insurance coverage in relation to its provision of the benefits described in paragraphs (a) and (b) of this section (or any combination of the benefits).

(a) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances:

(1) Coverage only for accident (including accidental death and dismemberment).

(2) Disability income insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Coverage issued as a supplement to liability insurance.

(5) Workers' compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) Credit-only insurance (for example, mortgage insurance).

(8) Coverage for on-site medical clinics.

(b) *Other excepted benefits.* The requirements of this part do not apply to individual health insurance coverage described in paragraphs (b)(1) through (b)(6) of this section if the benefits are

provided under a separate policy, certificate, or contract of insurance. These benefits include the following:

(1) Limited scope dental or vision benefits. These benefits are dental or vision benefits that are limited in scope to a narrow range or type of benefits that are generally excluded from benefit packages that combine hospital, medical, and surgical benefits.

(2) Long-term care benefits. These benefits are benefits that are either—

(i) Subject to State long-term care insurance laws;

(ii) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Code; or

(iii) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(3) Coverage only for a specified disease or illness (for example, cancer policies), or hospital indemnity or other fixed indemnity insurance (for example, \$100/day) if the policies meet the requirements of §146.145(b)(4)(ii)(B) and (b)(4)(ii)(C) of this subchapter regarding noncoordination of benefits.

(4) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss, also known as Medigap or MedSupp insurance).

(5) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as CHAMPUS supplemental programs).

(6) Similar supplemental coverage provided to coverage under a group health plan.

[62 FR 16995, Apr. 8, 1997; 62 FR 31696, June 10, 1997]

Subpart E—Grants to States for Operation of Qualified High Risk Pools

SOURCE: 68 FR 23414, May 2, 2003, unless otherwise noted.

§ 148.306 Basis and scope.

This subpart implements section 2745 of the Public Health Service Act (the PHS Act). It provides for grants to

States that have qualified high risk pools that meet the specific requirements described in §148.310. It also provides specific instructions on how to apply for the grants and outlines the grant review and grant award processes.

§ 148.308 Definitions.

For the purposes of this subpart, the following definitions apply:

CMS stands for Centers for Medicare & Medicaid Services.

Loss means the difference between expenses incurred by a qualified high risk pool, including payment of claims and administrative expenses, and the premiums collected by the pool.

Qualified high risk pool means a high risk pool that meets the conditions described in §148.128(a)(2)(ii):

(1) It provides to all eligible individuals, as defined in §148.103, health insurance coverage (or comparable coverage) that does not impose any pre-existing condition exclusion or affiliation periods for coverage of an eligible individual; and

(2) Provides for premium rates and covered benefits for the coverage consistent with the standards included in the National Association of Insurance Commissioners (NAIC) Model Health Plan for Uninsurable Individuals Act (as in effect as of August 21, 1996) but only if the model has been revised in State regulations to meet all of the requirements of this part and title 27 of the PHS Act.

Standard risk rate means a rate developed by a State using reasonable actuarial techniques and taking into account the premium rates charged by other insurers offering health insurance coverage to individuals in the same geographical service area to which the rate applies. The standard rate may be adjusted based upon age, sex, and geographical location.

State, for purposes of this subpart, means any of the 50 States and the District of Columbia or any entity to which a State has delegated the authority to conduct risk pool operations.

State fiscal year, for purposes of this subpart, means the fiscal year used for accounting purposes by either a State or a risk pool entity to which a State

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has delegated the authority to conduct risk pool operations.

[68 FR 23414, May 2, 2003, as amended at 69 FR 15700, Mar. 26, 2004]

§ 148.310 Eligibility requirements for a grant.

A State must meet all of the following requirements to be eligible for a grant:

(a) The State has a qualified high risk pool as defined in § 148.308.

(b) The pool restricts premiums charged under the pool to no more than 150 percent of the premium for applicable standard risk rates for the State.

(c) The pool offers a choice of two or more coverage options through the pool.

(d) The pool has in effect a mechanism reasonably designed to ensure continued funding of losses incurred by the State after the end of fiscal year 2004 in connection with the operation of the pool.

(e) The pool has incurred a loss in a period described in § 148.314.

§ 148.312 Amount of grant payment.

(a) An eligible State may receive a grant to fund up to 50 percent of the losses incurred in the operation of its qualified high risk pool during the period for which it is applying.

(b) Funds will be allocated to each eligible State in accordance with the following formula:

(1) The number of uninsured individuals is calculated for each eligible State by taking a 3-year average of the number of uninsured individuals in that State in the Current Population Survey (CPS) of the Census Bureau. For grants based upon State fiscal years 2002 and 2003, a 3-year average was calculated using numbers available as of September 30, 2003. For grants based upon State fiscal year 2004, a 3-year average will be calculated using numbers available as of September 30, 2004.

(2) Based upon the CPS numbers, the State's percentage of the total uninsured population of eligible States is calculated and then multiplied by \$40 million to determine the State's maximum allotment for the fiscal year in question. The following example illustrates the formula in paragraph (b):

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(i) The most current 3-year average of uninsured individuals in State A is one million, and the 3-year average of uninsured individuals for all eligible States is 10 million. State A has 10 percent of the uninsured population of the eligible States.

(ii) Under this example, State A's allotment would be 10 percent of \$40 million, or \$4 million, for the fiscal year in question.

(c) The amount awarded to each eligible State will be the lesser of the 50 percent of losses incurred by its qualified risk pool for the fiscal year in question or its allotment under the formula.

[68 FR 23414, May 2, 2003, as amended at 69 FR 15700, Mar. 26, 2004]

§ 148.314 Periods during which eligible States may apply for a grant.

(a) *General rule.* A State that meets the eligibility requirements in § 148.310 may apply for a grant to fund losses that were incurred during the State's fiscal year 2002, 2003, or 2004 in connection with the operation of its qualified high risk pool. If a State becomes eligible for a grant in the middle of its fiscal year, a State may apply for losses incurred in a partial fiscal year if a partial year audit is done. Only losses that are incurred after eligibility is established will qualify for a grant.

(b) *Maximum number of grants.* An eligible State may only be awarded a maximum of two grants, with one grant per fiscal year. A grant for a partial fiscal year counts as a full grant.

(c) *Deadline for submitting grant applications.* The deadlines for submitting grant applications are stated in § 148.316(d).

(d) *Initial distribution of grant funds.* States that meet all of the eligibility requirements in § 148.310 and submit timely requests in accordance with paragraph (c) of this section will receive an initial distribution of grant funds using the following methodology:

(1) *Initial grant applications submitted for losses incurred in State fiscal year 2002 (hereafter referred to as 02 States).* Initial grants to States that submitted an application for losses incurred in State fiscal year 2002 were funded out of the \$40 million appropriation for Federal

fiscal year (FFY) 2003, which is available for obligation until the end of FFY 2004. (This is referred to as the “initial \$40 million appropriation.”)

(2) *Initial grant applications submitted for losses incurred in State fiscal year 2003 (hereafter referred to as 03 States).* Initial grants to States that did not submit an application for losses in State fiscal year 2002 (or submitted an application but did not qualify) and first qualified for a grant for losses incurred in State fiscal year 2003 will be funded out of the initial \$40 million appropriation.

(3) *Initial grant allocations.* Initial grant allocations will be determined by taking all grant applications described in paragraphs (d)(1) and (2) of this section, and allocating in accordance with § 148.312.

(4) *Other applications.* All other grants, including the initial grants for the 04 States (States that initially qualify based upon losses incurred in their fiscal year 2004), will be funded out of the \$40 million appropriation for FFY 2004, which is available for obligation until the end of FFY 2005. (This is referred to as the “second \$40 million appropriation.”)

(e) *Allocation of funds.* Grants to States described in paragraphs (d)(1) and (d)(2) of this section will be allocated in accordance with paragraphs (e)(1) and (e)(2) of this section.

(1) *Initial allocation.* (i) *Reserves.* We will first determine the projected number of 03 States (those that are expected to submit their initial grant requests after the deadline for grants relating to a State’s 2002 losses). We will reserve the portion of the initial \$40 million appropriation that we estimate will be needed to fund grants for 03 States.

(ii) *Initial allocation to 02 States.* The remainder of the initial \$40 million appropriation will be allotted to the 02 States.

(iii) *Excess reserves.* If the initial allotments for any of the 02 or 03 States are less than 50 percent of the losses incurred by those States, any reserved funds that remain after allotments have been made to all 02 and 03 States will be proportionally redistributed to the 02 and 03 States, but not to exceed 50 percent of losses incurred by the States. The size of the initial grants

will be increased retroactively for those States.

(2) *Second allocation.* The procedure described in paragraph (e)(1) of this section will also be applied to allocate the second \$40 million appropriation. A reserve will be established based on the amounts expected to be needed to fund grants to 04 States before funds are allocated for second year grants for 02 and 03 States. If any excess funds remain after States receive their full allotments, the funds will be proportionally distributed to States whose allotments were less than 50 percent of their losses.

[68 FR 23414, May 2, 2003, as amended at 69 FR 15701, Mar. 26, 2004]

§ 148.316 Grant application instructions.

(a) *Application package.* Each State must compile an application package that documents that it has met the requirements for a grant. If a risk pool entity applies on behalf of a State, it must provide documentation that it has been delegated appropriate authority by the State. At a minimum, the application package must include a completed standard form application kit (see paragraph (b) of this section) along with the following information:

(1) *History and description of the qualified high risk pool.* Provide a detailed description of the qualified high risk pool that includes the following:

(i) Brief history, including date of inception.

(ii) Enrollment criteria (including provisions for the admission of eligible individuals as defined in § 148.103) and number of enrollees.

(iii) Description of how coverage is provided administratively in the qualified high risk pool (that is, self-insured, through a private carrier, etc.).

(iv) Benefits options and packages offered in the qualified high risk pool to both eligible individual (as defined in § 148.103) and other applicants.

(v) Outline of plan benefits and coverage offered in the pool. Provide evidence that the level of plan benefits is consistent with either Alternative One or Alternative Two in Section 8 of the NAIC Model Health Plan for Uninsurable Individuals Act. See Appendix for

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the text of Section 8 of the NAIC Model.

(vi) Premiums charged (in terms of dollars and in percentage of standard risk rate) and other cost-sharing mechanisms, such as co-pays and deductibles, imposed on enrollees (both eligible individuals (as defined in §148.103) and non-eligible individuals if a distinction is made).

(vii) How the standard risk rate for the State is calculated and when it was last calculated.

(viii) Revenue sources for the qualified high risk pool, including current funding mechanisms and, if different, future funding mechanisms. Provide current projections of future income.

(ix) Copies of all governing authorities of the pool, including statutes, regulations and plan of operation.

(2) *Accounting of risk pool losses.* Provide a detailed accounting of claims paid, administrative expenses, and premiums collected for the fiscal year for which the grant is being requested. Indicate the timing of the fiscal year upon which the accounting is based. Provide the methodology of projecting losses and expenses, and include current projections of future operating losses (this information is needed to judge compliance with the requirements in §148.310(d)).

(3) *Contact person.* Identify the name, position title, address, e-mail address, and telephone number of the person to contact for further information and questions.

(b) *Standard form application kit*—(1) *Forms.* (i) The following standard forms must be completed with an original signature and enclosed as part of the application package:

SF-424 Application for Federal Assistance
SF-424A Budget Information
SF-424B Assurances Non-Construction Program
SF-LLL Disclosure of Lobbying Activities
Biographical Sketch
Additional Assurances

(ii) These forms can be downloaded from the following Web site:

<http://www.cms.hhs.gov/researchers/priorities/grants.asp>.

(2) *Other narrative.* All other narrative in the application must be submitted on 8½×11" white paper.

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(c) *Submission of application package.*

(1) Applicants are required to submit an original and two copies of the application. Submissions by facsimile (fax) transmissions will not be accepted.

(2) Applications mailed through the U.S. Postal Service or a commercial delivery service will be considered “on time” if received by the close of business on the closing date, or postmarked (first class mail) by the date specified in the paragraph (d) of this section. If express, certified, or registered mail is used, the applicant should obtain a legible dated mailing receipt from the U.S. Postal Service. Private metered postmarks are not acceptable as proof of timely mailings.

(d) *Application deadlines*—(1) *Deadline for States to submit an application for losses incurred in their fiscal year 2002.* States must submit an application to us by no later than September 30, 2003.

(2) *Deadline for States to submit an application for losses incurred in their fiscal year 2003.* States must submit an application to us by no later than June 30, 2004.

(3) *Deadline for States to submit an application for losses incurred in their fiscal year 2004.* States must submit an application to us by no later than June 30, 2005.

(e) *Where to submit an application.* All initial applications and supplemental applications must be submitted to:

Centers for Medicare & Medicaid Services,
Acquisition and Grants Group, Mail Stop
C2-21-15, 7500 Security Boulevard, Baltimore, MD 21244-1850, Attn: Nicole Nicholson.

[68 FR 23414, May 2, 2003, as amended at 69 FR 15701, Mar. 26, 2004]

§ 148.318 Grant application review.

(a) *Executive Order 12372.* This grant program is not listed by the Secretary under §100.3 of this title, and therefore the grant program is not subject to review by States under part 100 of this title, which implements Executive Order 12372, “Intergovernmental Review of Federal Programs” (see part 100 of this title).

(b) *Review team.* A team consisting of staff from CMS and the Department of Health and Human Services will review all applications. The team will meet as

necessary on an ongoing basis as applications are received.

(c) *Eligibility criteria.* To be eligible for a grant, a State must submit sufficient documentation that its high risk pool meets the eligibility requirements described in §148.310. A State must include sufficient documentation of the losses incurred in the operation of the qualified high risk pool in the period for when it is applying.

(d) *Review criteria.* If the review team determines that a State meets the eligibility requirements described in §148.310, the review team will use the following additional criteria in reviewing the applications:

(1) *Documentation of expenses incurred during operation of the qualified high risk pool.* The losses and expenses incurred in the operation of a State's pool are sufficiently documented.

(2) *Funding mechanism.* The State has outlined funding sources, such as assessments and State general revenues, which can cover the projected costs and are reasonably designed to ensure continued funding of losses a State incurs in connection with the operation of the qualified high risk pool after fiscal year 2004.

§ 148.320 Grant awards.

(a) *Notification and award letter.* (1) Each State applicant will be notified in writing of CMS's decision on its application.

(2) If the State applicant is awarded a grant, the award letter will contain the following terms and conditions:

(i) All funds awarded to the grantee under this program must be used exclusively for the operation of a qualified high risk pool that meets the eligibility requirements for this program.

(ii) The grantee must keep sufficient records of the grant expenditures for audit purposes (see part 92 of this title).

(iii) The grantee may be required to submit quarterly progress and financial reports under part 92 of this title.

(b) *Grantees letter of acceptance.* Grantees must submit a letter of acceptance to CMS' Acquisition and Grants Group within 30 days of the date of the award agreeing to the terms and conditions of the award letter.

PART 149 [RESERVED]

PART 150—CMS ENFORCEMENT IN GROUP AND INDIVIDUAL INSURANCE MARKETS

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